

MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-004213

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

686

STATE FILE NUMBER

1. PLACE OF DEATH

a. COUNTY - - - - -

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR
TOWN

St. Louis, Missouri

Length of stay in 1b

4 hours

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

St. Anthonys Hospital

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

Mo

c. CITY
OR
TOWN

3209 Childress

St. Louis 9, Mo.

Inside Limits

Yes ☐ No ☐d. STREET
ADDRESS

(If outside, give location)

3209 Childress

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Charles

F.

Metzinger

4. DATE
OF
DEATH

Month

Day

Year

January

13

1962

5. SEX

M

6. COLOR OR RACE

W

7. Married ☒Never Married ☐Widowed ☐Divorced ☐

8. DATE OF BIRTH

1-14-1895

9. AGE (last birthday)

66

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Pressman Foreman

10b. KIND OF BUSINESS OR INDUSTRY

Printing

11. BIRTHPLACE (City and state or country)

St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

William J. Metzinger

13b. MOTHER'S MAIDEN NAME

Mary Alice Beeson

14. NAME OF HUSBAND OR WIFE

Grace Metzinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

Yes

WW I

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Grace Metzinger 3209 Childress

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinoma Bladder

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Myocardial Cha

DUE TO (c)

181.0

INTERVAL BETWEEN
ONSET AND DEATH

1960 +

1961 +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

6/20/1958 to 1/12/62

and last saw her
him alive on 1/12/62

Death occurred at

2:32

m on

the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Robert P. Smith M.D.

22b. ADDRESS

5203 Cluffman Dr

22c. DATE SIGNED

1/16/62

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Removal

23b. DATE

Jan. 16, 1962

23c. NAME OF CEMETERY OR CREMATORY

Laurel Hill Gardens

23d. LOCATION (City, town, or county)

St. Louis County

(State)

Mo.

24. FUNERAL DIRECTOR

ADDRESS

HOFFMEISTER COLONIAL MORTUARY

25. DATE RECD. BY LOCAL REG.

JAN 16 1962

26. REGISTRAR'S SIGNATURE

Robert P. Smith, M.D.

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
 or by _____, Student Embalmer No. _____
 working under my personal supervision.

Student _____ Signed *Bill C. Graham*
Signature of Student Embalmer

Licensed Embalmer No. *4764*

P. O. Address *St Louis Mo*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).
 If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.
 If this body is not embalmed, fact should be so stated above.